MEDICAL RELEASE APPROVAL AND AUTHORITY

Applicant/Patient Name____

Applicant/Patient D.O.B.______________________________________

PHYSICIAN'S NAME ______________________________________

PHYSICIAN'S ADDRESS ___________________________________

PHYSICIAN'S PHONE ____________________________________

PHYSICIAN'S STATEMENT

I, (Printed name of physician)________________________, the attending physician, by signing this application, release (Printed Name of Applicant/Patient)__________________, for the activities involved in hunting and handling firearms.

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Physician's Signature____________________________ **DATE** _____________

* ***PLEASE NOTE THAT YOUR APPLICATION CANNOT BE CONSIDERED WITHOUT PROPER SIGNATURES. ONCE WE RECEIVE YOUR SIGNED COPY WE WILL PROCESS YOUR APPLICATION AND NOTIFY YOU OF OUR CONSIDERATION AND OPPORTUNITY FOR OUR UPCOMING EVENTS.***